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Policy

Policy change and policy dilemmas: interpreting the community services White Paper in England

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Abstract

Context: In 2006 the Labour Government in England published its long awaited White Paper on ‘community services’, following on from the 2005 Green Paper on the future of social care. The policy envisages an unprecedented shift of activity and resources from acute care to community settings, along with a much stronger focus on preventive care. Several mechanisms are to be put in place to ensure this shift takes place, most notably practice-based commissioning, payments-by-results and enhanced partnership working.

Purpose: This article outlines the intended changes and assesses the extent to which they add up to a coherent strategy.

Conclusion: It is argued that although there is widespread support for the overall vision, the strategy contains some difficult policy tensions that are common to other welfare systems. These will have to be addressed if the vision is to be a reality.

Keywords

community services, integration, England, policy dilemmas, policy implementation, ambiguity, conflict

Introduction

In January 2006 the Labour Government in Britain published its White Paper on ‘community services’ [1]. The term ‘community services’ is not self-evident, but as used in the White Paper seems to encompass, at a minimum, primary health care, community health and social care services. The fact that these services should be candidates for ‘integration’ is a reflection of the extent of service fragmentation that has arisen in the English context since the creation of the NHS in 1948. Despite the self-evident connections between them, the funding, structure and accountability of general practitioners, community nurses and social care professionals has continued to be separate, and the longer this has persisted the more difficult it has been to introduce change. Such dilemmas are neither new, nor are they confined to England and the rest of the UK [2–6].

The context: partnership working in the UK

In England, the early 1960s saw the first attempt to coordinate health and social services through national

planning systems, with the introduction of ten year plans for hospital and community care services, respectively. However, local authorities were merely exhorted to take account of proposed developments within hospital services, and central government had neither the means nor the inclination to ensure that the two sets of plans were brought together at local level. The 1974 reorganisation of the NHS sought—through the creation of new Area Health Authorities—to bring the different health services under the same organisational umbrella. The main way in which it did this was by moving most of the local health authority services out of local government and into the NHS. The list of transferred services was long, covering community health services for mothers and pre-school children, school health, vaccination and immunisation, home nursing, health visiting, domiciliary midwifery, family planning, health education, chiropody and ambulance services [7].

However, changing the boundaries and remits of some agencies invariably throws up new problematic inter-sections. General practitioner services continued to be separately administered and funded, and remained outside mainstream NHS planning and service co-ordination mechanisms [8]. Moreover, although the

changes were intended to secure a more integrated approach to the provision of *health care* services, they also had the potential to further deepen the cleavage between health and social care services, as well as other local authority services which contributed to health and well-being. In particular, the changes reduced the potential for social workers in social services departments (which had been set up in 1971) to work closely with community nurses, who now had different employers and possibly different priorities.

The amount of joint planning that resulted from the 1970s initiatives was generally disappointing [9]. Part of the reason for this was argued to be the over-emphasis on structural links and processes, and the failure to consider broader planning issues—in other words, a pre-occupation with *means* rather than *ends* [10]. The seeming general inability of health authorities and local authorities to work together began to attract political interest as the 1980s progressed, and in the wake of this sustained criticism, Sir Roy Griffiths was commissioned by the Conservative Government to conduct an independent review of the financial and organisational arrangements for community care. His report denounced the approach of central government to joint working as “*the discredited refuge of imploring collaboration and exhorting action*” [11], but he also emphasised that mandatory administrative restructuring would be unduly disruptive.

The main principle on which his changes were based was the separation of responsibilities for purchasing and providing. Purchasing power was to remain in the hands of agencies acting on behalf of individuals, but these proxy consumers were able to choose who should provide the services. The notion of ‘state welfare’, based upon an implicit conflation of purchasing and providing roles was to disappear. Although the ‘internal market’ model in the NHS restricted most purchasing to public sector providers, the social care market model rested upon purchasing more services from the independent sector. The intention was that provider competition would provide incentives for greater responsiveness to the needs of consumers while also being more attentive to cost and quality, and at the same time purchasers would be freed from protecting the vested interests of in-house providers. As far as collaboration was concerned, the inference seemed to be that purchasers could simply require providers to work jointly through contractual obligations.

The introduction of markets posed a fundamental dilemma: while collaboration has long been recognised as the essence of effective service delivery in health and social care, the essence of markets is competition. There is little doubt that the Conservative

Government of the time did *not* see the two as mutually exclusive. However, while the collaborative imperative dictated that these purchaser–provider relationships should be based upon long-term, trusting relationships, the competitive imperative required the maintenance of competition *between* providers—a difficult balancing act to achieve. Private home owners, for example, were seeking the security of a stable price and a guaranteed share of the market from local authority purchasers, whereas some local authorities were looking to drive down costs through competitive tendering.

The Labour Government came to power in May 1997 with a clear view that the quasi-market approach to health and social services had been a failure, and that the key to effective service planning and delivery lay in the development of ‘partnerships’. Health ministers referred repeatedly to the need to break down the ‘Berlin Wall’ between health and social services, and managers of both services were warned that collaboration was no longer an optional extra. The shift in values seemed to be clear; collaboration was not simply back on the agenda, but was at the very heart of new policies on health and social care in the shape of ‘partnership’. In particular Section 31 of the 1999 Health Act introduced three types of arrangements described as ‘flexibilities’—lead commissioning, pooled budgets and integrated provision. Progress has been at best patchy [12,13] and at times the Government has been tempted to go back to a restructuring solution through the creation of Care Trusts [14].

All change: the community services White Paper

It is in this context that the pursuit of inter-professional and inter-agency coordination is still on the policy agenda—this time with the community services White Paper of 2006. The strategy follows on from the 2005 Green Paper on social care [15], but is wider in scope on the ground that social care cannot be sensibly considered in isolation from other community services—service inter-dependency has become the justification for putting social care reform in a broader context. The imperative is avowedly integrationist, moving beyond notions of discrete, *ad hoc* partnerships towards a ‘whole system’ model which delivers customised services to individuals. In his Introduction, for example, the Prime Minister states:

These proposals will allow us to accelerate the move into a new era where the service is designed around the patient, rather than the needs of the patient being forced to fit around the service already provided

The vision of the White Paper is sweeping. In her Foreword, the Health Secretary says that it '*lays out a lasting and ambitious vision*' by creating health and social care services that:

- genuinely focus on prevention and promoting health and well being;
- deliver care in more local settings;
- promote the health of all, not just a privileged few;
- and deliver services that are flexible, integrated and responsive.

As a result of the measures, the Health Secretary accordingly predicts (p. 4) that:

- people will be helped in their goal to remain healthy and independent;
- people will have real choices and greater access in both health and social care;
- far more services will be delivered—safely and effectively—in the community or at home;
- services will be integrated, built around the needs of individuals and not service providers, promoting choice and independence;
- long standing inequalities in access and care will be tackled.

Chapter 1 of the White Paper goes on to lay out '*three simple themes*' that constitute the vision:

- *putting people more in control of their own health and care*: a fundamental aim is to make the actions and choices of people who use services the drivers of improvement;
- *enabling and supporting health independence and well being*: people want to maintain their own health, a sense of personal well being and lead an independent life;
- *rapid and convenient access to high quality, cost-effective care*: services in places, and at times, that fit in with the way that they lead their lives.

These themes reflect what is termed '*the public's priorities*' arising from the lengthy consultation exercise, to which could be added a fourth theme contained in these priorities—services that '*meet the whole of their needs, particularly if these are ongoing...not just focusing on sickness or an immediate crisis*' (p. 15).

The White Paper proposals

The specific proposals contained in the White Paper are diverse and overlapping, but can be placed in four main categories:

- better access to community services
- integrated operational arrangements
- supporting self care
- user empowerment

Better access to community services

The position taken in the White Paper is that the balance of activity and resources between secondary care and community services needs to be shifted away from the former and towards the latter. Evidence from elsewhere is cited to support the proposed policy shift. It is noted that care is delivered closer to home in many other countries and the percentage of the UK health budget going on 'primary care services' is calculated at 27%, compared with an OECD average of 33%. Currently there are nearly 45 million outpatient appointments every year in England and it is suggested that up to half of these could eventually be provided in a community setting. Hospitals, it is argued, '*can then devote themselves to meeting the clinical needs that they are uniquely equipped to meet*' (p. 137). This improved access is part of the intention to develop a 'health and well being' agenda supported by higher growth in prevention, primary and community care than in secondary care, and by shifting resources from the latter to the former.

Integrated operational arrangements

The White Paper recognises that if support is to be personalised as well as integrated there will have to be changes to operational arrangements. It is proposed to offer integrated health and social care plans to those whose needs go beyond information—a plan that will '*follow a person as they move through the care system*' (p. 115). The initial focus will be on offering such plans to those with complex health and social care needs and it is recognised that this will require changes to the way kindred professionals are organised and located. As a starting point the White Paper stresses the need for someone to act as a single point of contact to coordinate support for people whose needs are complex.

However, the white paper goes beyond the care management role towards what it terms '*multi-disciplinary networks and teams*' which will:

...need to operate on a sufficiently large geographic scale to ensure the involvement of all the key players, including social services, housing and NHS primary, voluntary, community and secondary care services.

Emphasis is also placed upon the co-location principle. Para 6.48 states that:

Our vision is that people who access health and social care services should also be able to easily access other services such as benefits and employment advice all from the same place.

Supporting self care

As well as making services more integrated and accessible, the White Paper proposes to support people to take better control of their care and condition. The Expert Patients Programme (EPP) currently provides training for people with a chronic condition to develop the skills they need to take effective control of their lives, led by people who have personal experience of living with a long-term illness. EPP capacity will be increased from 12,000 course places a year to over 100,000 by 2012 delivered by a 'community interest' company from which health and social care organisations can commission courses.

The White Paper further proposes to develop a new NHS '*Life Check*' service to help people—particularly those at critical points in their lives—to assess their own risk of ill-health. This will be a personalised service in two parts—an initial assessment for people to complete themselves; and offers of specific advice and support on actions that can be taken. The check will be available on-line or locally on paper, and people whose self-assessment indicates that they are at significant risk of poor health will be able to discuss the outcome with a 'health trainer'. For adults the approach will initially be developed for people around the age of 50 and will focus upon areas with the worst health and deprivation—the 'spearhead' areas. The Life Check strategy will be developed and evaluated in 2007 with a view to roll-out thereafter.

Finally, the White Paper recognises that people need and want access to better information. During the consultation process, people said that sources of information on health and local authority services were not linked, and expressed a wish for information to suit individual needs rather than organisational boundaries. It is, therefore, proposed to introduce '*information prescriptions*' for those with long-term conditions to enable them to access a wider provision of services. These, it is said, '*will be given to people using services and their carers by health and social care professionals...to signpost people to further information and advice to help them take care of their own condition*' (p. 114).

User empowerment

Following a strong consultation response, the White Paper proposes to extend the availability of direct

payments, whereby care budgets can be handed directly to service users, to those groups who are excluded under existing legislation. Although there have been increases in the numbers receiving direct payments (from 9000 adults in 2002/3 to 24,500 in 2004/5) this is said to be only a small fraction of the number who could benefit. However, the proposed 'individual budgets' go further than direct payments. The latter only cover local authority social care budgets whereas the former will bring together separate funds from a variety of agencies including local authority social services, community equipment, Access to Work, independent living funds, disabled facilities grants and the Supporting People programme. Individuals who are eligible for these funds will have a single transparent sum allocated to them and will be able to choose to take this in the form of a direct payment as cash, as provision of services, or a mixture of the two up to the value of their budget—a change that could revolutionise the way services are commissioned and delivered.

The levers of change

To bring about such big changes will require money, and the basic funding proposal in the White Paper is to change the balance of expenditure between community and secondary services. The strategy seems to be twofold—to prioritise community services in future spending growth, and to transfer existing resources from the secondary to the community sector. However, the White Paper remains coy about precisely what scale of resources will be transferred and by when. The Health Secretary says that within ten years she wants to see 5% of the hospitals budget in England transferred to primary and community services—some £2.4 billion a year by the end of the period, although the White Paper shies away from actually quoting a figure.

The ambition of the White Paper to change the balance of care is challenging—it is admitted that it means a need '*to realign the system radically away from its current pattern*' (p. 16). Indeed, this language of transformational policy recurs throughout the document with references to '*nothing less than a fundamental change in the way health and social care operates*' (p. 154) and '*changing the way the whole system works*' (p. 192). Essentially this refers to the fundamental policy challenge—to move from a fragmented and acute care dominated system to one that is coordinated and community oriented. The hope is that this will be achieved through changes in the ways local services are commissioned, and three commissioning levers can be identified—practice based

commissioning, payments by results and joint commissioning.

Practice based commissioning

The origin of what is now being termed 'practice based commissioning' (PbC) lies in the 1998 White Paper '*The New NHS*' [16] which stated that over time the Government expected indicative budgets for the full range of services to be extended to individual general practices. The later *NHS Improvement Plan* [17] said that practices would, if they wished, be able to have an indicative budget from April 2005 to commission a full range of services, and subsequent guidance published by the Department of Health in October 2004 gave further detail on what the scheme would entail [18].

The 2004 Guidance made it clear that all services could be commissioned by a practice except for those identified as 'specialist', which should be commissioned by consortia of Primary Care Trusts (PCTs), the local health authorities that currently have commissioning responsibility. The Government's intention is to achieve universal coverage of PbC by the end of 2006, but it remains the case that it is voluntary for practices. To encourage GPs to engage with the process, there is an incentive payment and flexibility in the extent of the potential remit, with the possibility of opting initially for only a limited range of services such as high volume elective care, a specific long-term condition or community services. The more ambitious practices may choose to work collectively with other practices as multi-practice corporate entities taking full collective accountability for commissioning decisions.

The promise of PbC is certainly grasped in the community services White Paper where it is argued that:

Practice based commissioning will provide incentives to avoid unnecessary stays in hospitals...and devote more resources to cost-effective prevention, including social care (para 7.42).

With some conceptual stretching, it goes on to describe PbC as 'the health equivalent of individual budgets in social care' (para 7.43). It is expected to 'lead to the development of more responsive and innovative models of joined-up support within communities' (para 7.45).

Payment by results

If practice-based commissioning identifies the main new *agents* of the commissioning arrangements, tariff-

based commissioning or payments by results (PbR) is the main new *mechanism*. The principle underpinning PbR is that instead of relying on historic budgets and locally negotiated contracts, providers of NHS services will be funded through a single rules-based system in which payments are directly related to the work undertaken. Activity classified according to healthcare resource groups (HRGs) will be paid for at a national tariff, leaving commissioners and providers to negotiate on volumes and quality. PbR is already underway. NHS Foundation Trusts and the PCTs that contract with them started to use the system from April 2004 for acute in-patient activity, both elective and non-elective. On April 1st 2005 it was introduced for elective activity in all other NHS trusts, but coverage of non-elective and outpatient care was deferred until April 2006 due to concerns about the reliability of the tariff in the face of unstable activity levels. Indeed, this deadline was then further extended in the light of problems in calculating the tariff.

Further extension is planned to cover electives, non-electives, A&E and outpatients in all hospitals in 2006/7, followed by a PbR mental health pilot in 2007. It is estimated that PbR will determine how around 30% of NHS funds are spent in 2006/7—£22 billion compared with only £9 billion in 2005/6. The tariff will be again extended to activity delivered in community based alternatives to acute hospitals from 2007/8. This is a big challenge for the PbR model. When a spell of care is clearly defined by diagnosis, need, duration and intervention, allocating a cost is relatively straightforward—a hip operation, for example, should be very similar in nature wherever it is performed across the country. Extending the approach to complex long-term conditions with no clearly defined outcome will be a much more difficult task.

If successful, PbR would have a number of benefits. Providers will have an incentive to increase activity in areas where the tariff is greater than marginal cost, and to reduce costs per case, for example through reducing length of stay. Commissioners will have an incentive to manage demand for acute services in order to reduce unnecessary admissions and develop community based alternatives to hospital care where it is appropriate and cost-effective to do so [19].

Joint commissioning

Much is expected of a commissioning partnership between local authorities and the local health authorities—the PCTs. Together, it is claimed, '*they will drive the radical realignment of the whole local system, which includes services like transport, housing and leisure*' (para 1.45). The White Paper states that the

Government will ‘*encourage more joint commissioning between primary care and local authority teams*’ (para 7.45) and in support of this will develop guidance on joint commissioning for health and well being by the end of 2006. It is critical of current commissioning for people with long-term needs, arguing that this has too often been episodic and organisational rather than focused on individuals. Joint commissioning in this area is said to be crucial because 80% of those using social care also have a long-term health care need.

The White Paper acknowledges that there are practical barriers that get in the way of joint planning to deliver common aims. The different organisations that need to work together to meet these outcomes have different planning and budgeting cycles created in part by central government fragmentation, and these need to be brought into line with each other. The Government accordingly proposes to align the planning and budgeting cycle for the NHS with the timetable for local government planning and budget-setting, making a start in 2007/8. There is also criticism that the performance assessment regime for PCTs is overly focused on provider output measures such as the number of patients breaching hospital access maximum waits. The new regime, it is said, will focus more broadly on how well PCTs succeed in meeting the health needs and expectations of their populations. More radically the White Paper concedes that for truly effective joint commissioning to occur, the performance management and assessment systems of health and social care need to be aligned. It promises that ‘*by 2008 we will ensure that both performance management systems are synchronised and that they clearly encourage good joint commissioning*’ (para 7.63).

Policy dilemmas and policy implementation

There is no doubting the ambition of the community services White Paper and the determination of the Government to oversee a radical realignment of the health and social care system. However, fresh policies rarely totally replace preceding arrangements and they have to find space in a crowded policy arena that is often populated with competing imperatives and interests. During the course of implementation this can result in some issues becoming the subject of conflict between vested interests, with particularly contentious matters being addressed by increasing the ambiguity of their intention.

In trying to understand this position, use will be made of Rick Matland’s ‘*Ambiguity-Conflict Matrix*’ [20]. For

Matland, the policy implementation literature has been unhelpfully split into two major schools—top-down and bottom-up—with a tendency for the former to study relatively clear policies, and the latter those policies with greater inherent uncertainty. He goes on to suggest that this difference has two features—ambiguity and conflict—and that building a more effective model of implementation requires evaluation of these policy characteristics.

He argues that *policy conflict* will exist when more than one stakeholder sees a policy as directly relevant to its interests and when these stakeholders have incongruous views. Such differences can arise regarding either the putative goals of a policy, or the implementation schedule and activities. *Policy ambiguity* can refer to ambiguity of goals and means. In top-down models, goal clarity is an important factor that directly shapes policy success, but one of the ways to limit conflict is through ambiguity. Ambiguity also affects policy means, for example when there are uncertainties about what roles various stakeholders will play in the implementation process. Building on this, Matland proposes his *ambiguity-conflict matrix* with each quadrant showing the type of implementation process and the central principles determining outcomes for this type of implementation. This has been adapted to describe more fully some of the key features within each quadrant (Table 1).

Although ambiguity and conflict are presented as dichotomous, this is strictly to simplify the exposition. Matland emphasises that the theoretical constructs are *continuous*. As a policy gradually moves across a dimension, for example, from low to high conflict, the implementation process is expected increasingly to show the characteristics of the quadrant being moved toward, and decreasingly to show the characteristics of the paradigm being moved away from. However, he argues that:

There is no tipping point at which a slight move up or down causes a radical shift from one type of implementation to another (p. 159).

The White Paper certainly contains discordant policy elements that are not readily reconcilable, and this increases the usefulness of Matland’s matrix. Six policy dilemmas can be identified:

- community services versus secondary services
- social care versus health care
- cost containment versus user-led outcomes
- commissioning flexibility versus provider stability
- partnership working versus organisational self-interest
- coherent governance versus market freedoms

Table 1 Matland's ambiguity-conflict matrix [adapted].

	Low conflict	High conflict
Low ambiguity	<p>Administrative implementation</p> <ul style="list-style-type: none"> • goals are given and a means for problem solving is known • a central authority has the information, resources and sanction capability to enact the desired policy • implementation is hierarchically ordered with each link receiving orders from the level above • policy is spelled out explicitly at each level and there is agreement on responsibilities and tasks • relatively uniform outcomes at the micro-level across many sites 	<p>Political implementation</p> <ul style="list-style-type: none"> • there is conflict over both goals and means • the implementation process is a key arena for conflict • implementation outcomes are determined by the distribution of power • compliance is not automatically forthcoming • low ambiguity ensures that monitoring of compliance is relatively easy
High ambiguity	<p>Experimental implementation</p> <ul style="list-style-type: none"> • outcomes depend largely on which actors are • involved variation in outcomes from site to site • outcomes are hard to predict • opportunities for local entrepreneurs to create local policies • compliance monitoring mechanisms are of limited relevance • the policy may become a low priority 	<p>Symbolic implementation</p> <ul style="list-style-type: none"> • ostensibly implausible combination • salient symbols can produce high levels of conflict even when the policy is vague • outcomes will vary across sites • outcomes will depend upon the balance of local coalition strength • policy ambiguity makes it difficult to monitor activities

Community services versus secondary services

The main thrust of any capital spending arising from the White Paper is in the form of community hospitals. It is said that *'over the next five years we will develop a new generation of modern NHS community hospitals'* (p. 143). These, it is said, will be places *'where a wide range of health and social care services can work together to provide integrated services to the local community'* (op cit). They will complement more specialist hospitals, serving areas of roughly 100,000 people and taking on some complex procedures such as surgery requiring general anaesthetic and providing accident and emergency facilities.

All of this represents a *volte-face* in respect of the acute hospital building programme embarked upon through the Private Finance Initiative (PFI) in which new NHS hospitals are built by private developers and leased back to the hospital trusts. The dilemma is only obliquely hinted at in the White Paper with the statement that *'primary care trusts, strategic health authorities and acute trusts will need to review their*

current plans for major capital procurement' to ensure these are in line with the movement of resources and activity into primary and community settings (p. 149). This is a real policy dilemma given that England is only part of the way through the biggest acute hospital building programme in the history of the NHS, with £9 billion still due to be spent on forty new PFI hospitals. Most of these contracts involve thirty year payback contracts, but the policy changes proposed in the White Paper cannot easily accommodate such lengthy deals. And there is the further problem that some sixty hospitals are already running such serious deficits that it will be difficult to shift resources into other settings without creating substantial financial instability.

Social care versus health care

The social care world in England is already fearful for its future following the transfer of children's social care from integrated social services departments into separate children's services authorities, and there is suspicion that the community services White Paper presages the takeover of adult social care by the

NHS. An electronic search of the White Paper shows that the term 'health' comes up 1125 times compared with 'social care' at 305 and only eighteen for social work, and this may reflect a tendency to see the policy world in NHS terms. Glasby [21] argues that this was apparent from the start when officials began talking of an *Out of Hospital* white paper—effectively defining community services by what they are *not* rather than in a more positive way couched around outcomes for service users. A similar tension is said to be evident between a health care notion of prevention (reducing hospital admissions) and a social care perspective concerned with supporting people to live chosen lifestyles. This emphasis on the NHS reflects the political and economic importance of health care, with its annual budget of over £70 billion, but the fear is that in the process there will be a loss of cherished social work values.

Cost containment versus user led outcomes

There is an economic issue underlying the new community strategy. Although the total budget for the NHS in England doubled between 1997 and 2005 (up to 8.4% of gross domestic product), the NHS has continued to be in a state of financial crisis. One of the key issues here has been the seeming inability of PCTs to control secondary care expenditure, with hospitals continuing to attract patients and suck in resources regardless of the appropriateness of hospital attendance or the effectiveness of treatments. The White Paper accordingly seeks to curb the dominance of the acute sector—indeed this may be the prime imperative.

The White Paper is meant to be an explication of the preceding social care Green Paper, but whereas the latter was an explicitly outcomes-based policy, the former is more focused upon means rather than ends. In the Green Paper, seven outcomes for adult social care were identified—improved health and emotional well being; improved quality of life; making a positive contribution; choice and control; freedom from discrimination; economic well being; and personal dignity. Although these outcomes are repeated in the White Paper they have not been more fully formulated and, indeed, have been relegated to the level of a sub-text. Henwood [22] argues that this represents a missed opportunity—merely re-stating the seven outcome headings does not provide the level of detail that is needed for performance objectives, targets and measures to be elaborated. She suggests that there is a level of confusion in the White Paper between ends and means, and that it is only after consensus is

achieved around outcomes that there can be any real progress in addressing what needs to be done to deliver the local change agenda.

Commissioning flexibility versus provider stability

Recent health policy in England has been characterised by mechanisms to ensure provider stability. Currently, if PCTs wish to make a significant change to their commissioning intentions, for example, they have to offer the provider trust six months notification, and to consult publicly on their intentions. And elsewhere in the system there are mechanisms that inhibit changes in commissioning habits. Foundation Trusts, for example, enjoy three year legal service contracts with PCTs, and PFI arrangements may involve hospitals guaranteeing funding flows to private partners for up to thirty years. On top of this there are political considerations, with local people invariably opposed to any possible loss of local acute services.

Such provider stability will be under threat with the new arrangements. PbC does not require any notice to be given of changes to commissioning arrangements, and PbR is explicitly intended to shift activity to community based alternatives. The Audit Commission [23] reported trusts to be already considering cutting services where their costs were well above tariff, but those with costs below tariff will get additional funds. It was estimated that 32 trusts had reference costs over 10% above or below the average (twelve of them above), and that some stood to gain up to £30 m while others could lose up to £50 m.

The issue of provider stability in a market setting is not confined to acute hospitals; the Government has also been keen to 'outsource' community health service provision, notably community nurses. The strong reaction to this proposal has resulted in some retreat from the original position, yet question marks remain over the future of community health services providers. Currently there is little contestability in community health services. By their nature they are often long-term and involve complex interactions between different health and social care agencies, whereas most health services provided outside of the NHS have tended to be stand-alone episodes of treatment or diagnosis.

It is uncertain whether alternative providers would see community health services as a worthwhile market but the Government does still seem to have designs on opening up the service to 'contestability'. Para 7.71 of the White Paper states that: *'there is no requirement or timetable for PCTs to divest themselves of*

provision', whereas para 7.83 seems less certain, stating that:

Where local reviews show that services are high quality, PCTs can continue with the existing provider—in many instances this will be the PCT itself...PCTs may also decide to look for new ways of providing services following a service review.

What this seems to add up to is a strategy of retention plus contestability—community nurses will retain provider stability if they can demonstrate market advantage. This is a difficult line to walk and may work against the desire for integrated provision.

Partnership working versus organisational self-interest

More effective partnership working is at the heart of the White Paper—partnership between providers, between commissioners and between commissioners and providers. However, since there is also a strong market imperative to promote more 'efficiency' it is likely that at some point the cooperative and competitive imperatives will clash. One of the most likely areas of conflict will be the ways in which acute providers may play the system in order to induce demand and maximise income, rather than assist in the shift to community based alternatives. Concerns about such 'gaming' have been raised by the NHS Alliance in a survey of PCTs and practice-based commissioners conducted in early 2006 [24] in which 80% of respondents said the system encouraged gaming by providers to maximise income.

Demand management initiatives cannot be introduced quickly or easily, and they will best be undertaken in partnership with others. The key partners will be practice-based commissioners (who have the financial incentive to engage in service redesign and referral management) and local authorities already engaged with the health and well being agenda. However, the financial position of the NHS as a whole deteriorated during 2004/5 with a larger number of health economies and individual institutions reporting deficits, and against this background the challenges of introducing PbR are likely to increase, with only a small chance of achieving a healthy tension between commissioners and providers.

Coherent governance versus market freedoms

The Government is attempting to sit on a difficult ideological fence. On the one hand it seeks to promote

a more coherent system-wide approach to health and care planning, but on the other hand it believes that change is best brought about by encouraging market incentives. One example is PbC, where GPs are permitted to conflate the purchasing and providing roles and retain 50% of any savings. This gives an incentive for practices to provide services 'in house', thereby potentially limiting the range of services on offer. The strategic risk posed here is that highly autonomous practices may fail to deliver on key service redesign that requires multi-institutional cooperation, and the planning and delivery of care pathways across sectors. As Lewis has put it, '*a justified scepticism as to whether sensible micro decisions will inevitably add up to sensible outcomes at the macro level*' [25].

What is missing is some clear governance arrangements in which the joint commissioning is conducted and shared decisions are reached. The nearest the White Paper comes to this is with the proposals for utilising Local Area Agreements (LAAs) and Local Strategic Partnerships (LSPs). In LAAs, local councils and central government agree 'stretched targets' and the delivery of a mix of national and local priorities through resources that might be pooled. The White Paper states that '*good partnership working requires clarity about what each partner will contribute to joint work...and mechanisms that help them plan to achieve them*' (para 2.68). It is noted that LSPs are positioned as the 'partnership of partnerships' and that LAAs will be a key development in helping to achieve good partnership working.

The reality, however, is that LAAs and LSPs have been local government led and oriented, and there are issues about the extent to which NHS agencies would choose to be part of this pattern of accountability. Moreover, this proposed mode of governance for joint commissioning is relatively untested and cannot be expected to compete with the commissioning clout of PbC and PbR. Indeed, recent research suggests that the freedoms and flexibilities negotiated in pilot LAAs are very limited in scope, and that central government still tends to behave in a fragmented and controlling manner [26]. All told, coherent governance is taking a back seat to market incentives, and the chance of 'whole systems working' is correspondingly reduced.

Conclusion: conflict and ambiguity

It has been argued in this paper that the community services White Paper in England has laudable

objectives but is characterised by unresolved policy dilemmas. The thrust of the analysis in this article is to suggest that currently the policy can be identified as one of *experimental implementation*, characterised by low conflict and high ambiguity. The vision articulated in the White Paper has been well received (apart from a muted response from the acute sector) but current levels of conflict are relatively low because in important respects the ambiguity of the strategy remains quite high. There is no certainty that the proposed shift in resources from acute to community settings will actually come about, the mechanisms for doing so (PbC and PbR) are untried and uncertain, there are no clear policy outcomes and no robust governance arrangements for delivering change. In such circumstances those who support the policy can live in hope, and those who oppose it can feel they will be around to fight another day.

However, the policy dilemmas identified in this article also suggest that at some point, the levers of change put in place by the Government will begin to bite—notably PbC, PbR, joint commissioning, individual budgets and joint performance measures. Although the effect of pulling on these levers is not accurately known, the likelihood is that community services policy will shift towards *political implementation* when tough decisions on alternatives will no longer be avoidable and stakeholders will have directly conflicting perspectives and interests. The message for policy implementation is that the move from experimental

implementation to political implementation needs to be carefully anticipated and properly managed otherwise the fine aspirations contained in the White Paper will become a future byword for policy failure.

These policy dilemmas are not mere idiosyncrasies of the English system; each of them is of enduring significance in the literature on welfare reform as nation states seek to reconcile the security of their citizens with economic realities and the role of the state with the role of the market. The outcome in the case of the community services White Paper is unclear, with the honeymoon phase of *experimental implementation* still underway. The next phase will reveal much about the extent to which a commitment to coordinated working at operational and strategic level can withstand the bargaining and reality of *political implementation*.

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